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# **A Comparison and Exploration of Burnout in Clinicians working with Offenders with Personality Disorders: A Service Improvement Project**

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## **Literature Review**

Mental health professionals have higher levels of burnout compared with other groups who work with people (e.g., teachers) (Crawford, Adedeji, Price, & Rutter, 2010; Fothergill, Edwards, & Burnard, 2004), leading to difficulties with retaining staff in mental health services (Evans et al., 2006). 'Burnout' was first defined by Maslach as a syndrome of emotional exhaustion, lack of personal accomplishment, and the development of cynicism (or 'depersonalisation') that can occur among individuals that do 'people-work' (Maslach & Jackson, 1981). Burnout should be distinguished conceptually from occupational stress; the latter is considered a transient and temporary phase of increased work-related stress. In contrast, burnout refers to prolonged occupational stress, where maladaptive beliefs and attitudes to one's work develop (Langan-Fox & Cooper, 2011).

Burnout is particularly common amongst those working with clients with Personality Disorders (PD) (Perseus et al., 2007). It has been proposed that working with 'difficult to treat' clients (such as those with a PD diagnosis), can foster reduced efficacy, self-esteem and exhaustion (Allen, 1997). In addition to this, Crawford et al., (2010) notes that working with aggressive or suicidal clients can be particularly stressful. Indeed, these characteristics are typically present in individuals with antisocial and borderline PD. Therefore, clinicians working with offenders with PD may be more susceptible to burnout when compared with other groups.

Delivering a high quality service is dependent on retaining a skilled workforce (Crawford et al., 2010), and it is therefore important to minimise the risk burnout in staff working with clients with PD. Research has sought to establish factors which may be seen as protective against burnout; regular supervision has been found to be protective against burnout in community mental health nurses (Edwards et al., 2006) and Crawford et al., (2010) note that supervision for clinicians engaging in therapies for treating PD (e.g., Mentalization Based Treatment (Bateman and Fonagy, 2004)) is integral to the therapeutic model. However, it remains to be seen whether supervision is a causal factor in reducing burnout in clinicians working with offenders with PD. It is therefore necessary to explore a range of strategies, factors and variables that may be protective against burnout in clinicians working in this field.

Whilst it is established that clinicians working with clients with PD are at increased risk of burnout, what is less evident in the literature is an exploration of *how* burnout is managed at a service level (Crawford et al., 2010), and also what personal resiliencies, coping resources and strategies are required to minimise burnout. This service improvement project aimed to answer some of these questions. Firstly, levels of burnout within a specialist forensic PD service are examined and compared to levels of burnout from a recent piece of research carried out within generic PD services. Subsequently, factors that may increase the prevalence of burnout within a forensic PD service are examined, and practical suggestions and strategies are gathered from clinicians as to how the risk of burnout can be minimised within the service.

## **Service Information**

The participating service was a specialist community-based forensic PD service. The service provides assessment, triage and intervention in the community for service users with a diagnosis of PD and a forensic history who pose a high risk of harm to others. The service also offers case management and consultation to other agencies. The service employs between 15 and 20 clinicians represented by a range of professional backgrounds (Nursing, Occupational Therapy, Clinical Psychology, Psychiatry etc.). The service offers placements and employment to student and trainee clinicians, and unqualified clinicians (e.g., assistant psychologists).

The aims for the project were generated at team meetings. It was suggested that high levels of occupational stress may be prevalent amongst clinicians, which may have been compounded by an ongoing service redesign. It was thought that a project assessing the prevalence of burnout and ways to reduce the risk of burnout would be useful. A formal proposal was discussed with the team who felt it was an acceptable project.

More generally, the service is continually expanding in terms of staffing: this project aimed to help the service think about how to support new staff or current staff members who may be at increased risk of burnout. It was hoped that the project would contribute towards general staff well-being and therefore staff retention and avoidance of sickness absence. This could be seen as aiding the retention of expertise and experience within the service, thus contributing to a high quality service.

## **Aims and objectives**

The identified aims for the project were:

1. To compare levels of burnout in clinicians working in a specialist forensic PD service with levels of burnout found in previous comparable research in generic PD services (Crawford et al., 2010).
2. To explore how burnout may arise within a forensic PD service, and the factors that may contribute to experiences of burnout. Further, to consider whether these factors are exclusive to a forensic PD setting.
3. To identify how the risk of burnout could be minimised or reduced within the service.

## **Method**

### ***Design, Sampling and Procedure***

A mixed methods design was employed. Clinicians that met inclusion criteria (n=16) were given questionnaire packs in a team meeting. Questionnaire packs were left for those who were absent from the meeting. A personal identification number was assigned to each participant, to ensure anonymity. Participants completed the questionnaire packs and returned them to the lead researcher (RC) by post.

The inclusion criteria for participation was:

- i. A minimum of six months working within the service.
- ii. Clinicians currently holding a clinical caseload.

It was felt necessary to exclude clinicians with less than six months experience to reduce the possibility that clinicians had simply not had ‘enough time’ to become burnt-out or that burnout was an effect of previous employment. Including staff that worked directly with service users ensured that the associated impact of working directly with this service user group could be assessed.

It was explained in the study information sheet that if participants had significant levels of burnout, this would be discussed with them in the first instance as to how this might be resolved (e.g., referral to occupation health, discussion with line manager etc).

## Measures

### • The Maslach Burnout Inventory (Maslach & Jackson, 1981) (MBI)

The MBI is a standardised, 22 item pen-and-paper questionnaire and is a widely used measure of burnout. The MBI has three subscales (Emotional Exhaustion, Depersonalization Reduced Personal Accomplishment) and possesses normed data with thresholds (>21, >8, <28, respectively) which represent clinically significant burnout. The MBI has been shown to have good internal consistency and test-retest reliability (Maslach & Jackson, 1981), with support having been found for the MBI’s three factor structure (Green & Walkey, 1988).

### • Focus group interview

All members of the clinical team were sent an email asking them to self-select for a focus group. The interview schedule for the focus group was based on the comments received from the clinical team in response to an initial questionnaire that had asked about strategies that clinicians found useful to reduce occupational stress. The team’s answers formed the basis for the interview schedule to enable a richer and fuller discussion of ideas that had been suggested. The questions on the interview schedule was developed by RC and AN to ensure that questions reflected the aims of the project.

Demographic and employment information was collected (see Table 1).

**Table 1: Demographic and Employment Information**

	Mean (Standard Deviation)	Range
<b>Length of Employment (months)</b>	37.22 (29.12)	6 – 78
<b>Contracted hours (per week)</b>	26.86 (11.53)	11.25 – 37.5
<b>Direct hours with Service Users (hours per week)</b>	3.22 (2.20)	0.5 – 7.5
<b>Indirect hours with Service Users (hours per week)</b>	17.33 (8.92)	5.0 – 30.0
<b>Supervision per month (hours)</b>	1.47 (1.08)	0.5 – 4.0
<b>Reflective practice per month (hours)</b>	0.94 (0.17)	0.5 – 1.0

## Analyses

### MBI

The mean and standard deviation of each of the three MBI subscales was compared to those found in Crawford et al. (2010) using independent t-tests (using pooled variance) to test for any statistical differences between the two datasets to give an illustrative comparison of burnout. The number of participants that met the threshold for clinically significant 'high' burnout with regards to the published norms was ascertained.

### Focus Group

Data from the focus group was analysed using Thematic Analysis, in accordance with the method described by Braun and Clarke (2006). The focus group transcript was coded by RC. RC and AN met to review codes, rename and define the themes to produce the final thematic maps. Themes were presented and validated by the clinicians at a team meeting; minor changes (e.g., the wording of some themes) were made.

The thematic analysis was driven from clear objectives and aims relating to burnout, and thus the data were coded in relation to these aims. The authors assumed a realist epistemology with regards to the data, in that the words and language used by participants reflected their experiences (Braun & Clarke, 2006). The authors felt that adopting this position would allow for a more pragmatic and clinically useful analysis of the data.

## Results

Of the 16 eligible participants, nine (56%) completed and returned the questionnaire packs. Six clinicians participated in the subsequent focus group.

Separate thematic maps were produced for: 'Perpetuation of the risk of burnout' (Figure 1) and 'Minimisation of the risk burnout' (Figure 2).

### Levels of Burnout

Mean levels of emotional exhaustion, depersonalization and personal accomplishment from the MBI are presented alongside those from the Crawford et al. study in Table 2. Four participants (28.6%) met the threshold for high Emotional Exhaustion, 1 (7.1%) for Depersonalization and 2 (14.3%) for low sense of Personal Accomplishment. Independent measures t-tests demonstrated no significant differences on the Emotional Exhaustion and Depersonalization subscales between the two studies. There was however a highly significant difference on the lack of Personal Accomplishment subscale.

Levels of burnout were elevated across all three subscales of the MBI, compared with the Crawford et al. study. In the current sample, four participants (28.6%) met the threshold for high Emotional Exhaustion, 1 (7.1%) for Depersonalization and 2 (14.3%) for low sense of Personal Accomplishment. However, the only subscale in which the mean score of the current sample exceeded clinically significant 'high' burnout (as compared to the normative data for the MBI) was Emotional Exhaustion. Of note, there was significant variation within the sample in reported Emotional Exhaustion (SD = 8.8).

**Table 2: A comparison of levels of burnout.**

Study	Sample	Emotional Exhaustion*	Depersonalization*	Personal Accomplishment**
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		( >21)	( >8)	( <28)
<b>Current project</b>	9 clinicians in a specialist Forensic PD service in England	23.7 (8.8)	5.1 (2.9)	30.33 (5.2)
<b>Crawford et al. (2010)</b>	87 clinicians working in specialist community PD services in England	17.7 (9.7)	4.4 (3.8)	36.6 (5.8)
<b>Significant difference</b>		No P = 0.07	No P = 0.59	Yes P = 0.01

\* Higher scores denote a higher sense of Emotional Exhaustion and Depersonalization

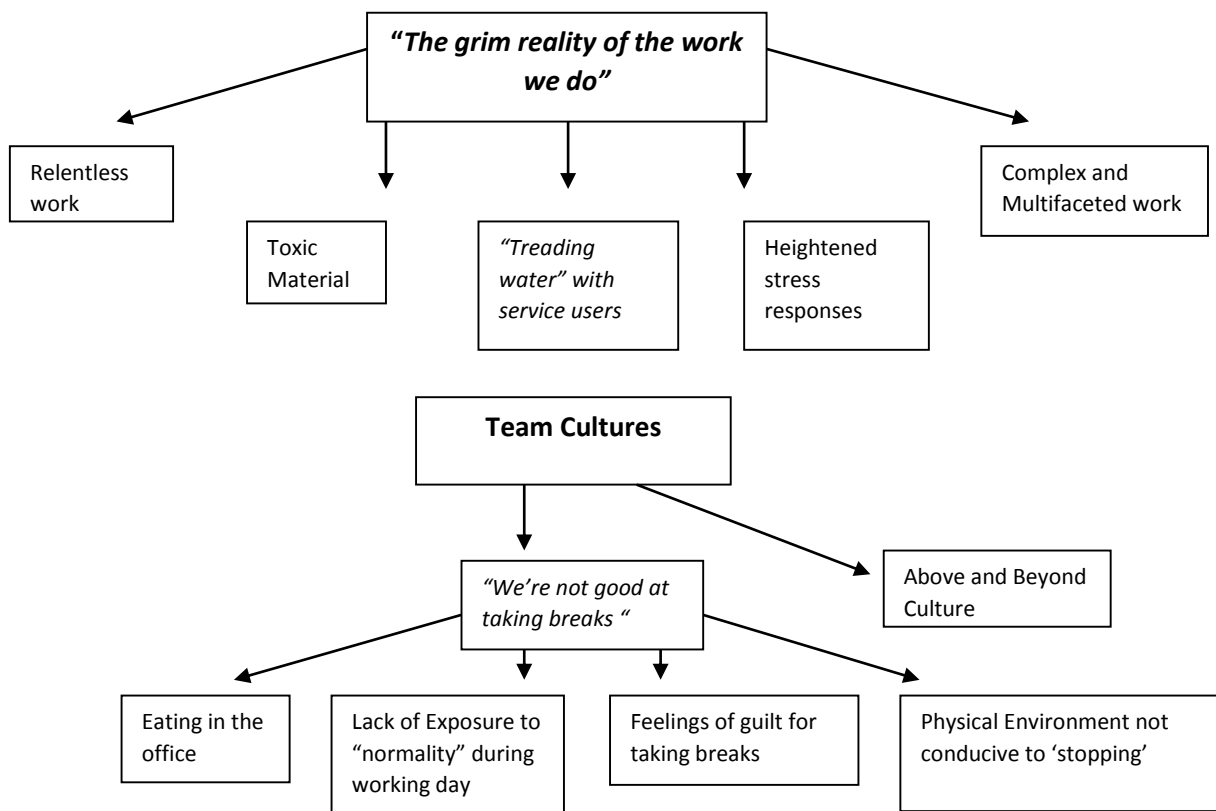
\*\* Lower scores denotes a lower sense Personal Accomplishment

### a. Perpetuation of the risk of burnout

Participant's names have been replaced with identification letters. The Jefferson Transcription System (Jefferson, 2004) has been utilised; Capital letters have been used to denote spoken emphasis, '[.]' denotes a pause in speech, '...' denotes removed text.

Two overarching themes were identified, relating to factors that perpetuated burnout within the forensic PD service. These were "the grim reality of the work we do" and team cultures.

**Figure 1: Thematic maps of the Perpetuation of the risk of burnout**



## 1. "The grim reality of the work we do"

Interviewees highlighted that forensic PD work has a distinct 'grim reality' to it, which is used as a term to summarise and comprised of the superordinate themes below. In summary, interviewees described the complex, emotionally demanding and multifaceted work that they engage in on a daily basis, which can be a source of stress. It might also be that the range of challenges that are faced within the work may be specific to forensic PD settings:

*C: "[In this field] I find myself doing a number of different roles... work can be incoming from a number of different directions and sometimes that can be really difficult to manage and it multiplies, and that is actually something I've noticed has caused me some issues in terms of management, and feeling JUST exhausted".*

In addition, the work can be complicated by the existential and philosophical questions that are raised when working with offenders with PD, which possibly is not as consistently present in other areas of mental health work:

*D: "one of the challenges in this line of work is that they're existential, a lot of the questions you're faced with [...] in terms of working with clients [...] constantly confronted with what's good about a human being [...] what has value in a life [...] what's worthwhile to work with when people [clients] are doing things that are kind of [...] what society says strips them of their rights".*

The above may be an example of added dimension to working with offenders with PD: the nature of the work means that clinicians have to be "exposed to fairly toxic material" (B), which requires them to ask philosophical and moral questions on a day-to-day basis. This was viewed as a source of internal unrest and the potential to contribute to a lack of personal accomplishment.

The aforementioned idea of being confronted by "toxic material" on a daily basis was recurring, which might suggest that there is an added risk of burnout when working with offenders with PD. "Toxic material" might take the form of reading information about the offender's life experience, regarding a service users index offence, or perhaps being confronted with service users whose presentations may be a source of discomfort for clinicians:

*B: "Working particularly with this client group... we're quite exposed to quite an extreme group, of perversion".*

*D: "you come across some pretty horrific cases which you wouldn't necessarily imagine somebody could do and that puts different layers on it".*

Therefore, clinicians are exposed to graphic paperwork; hearing scenarios of perverse offences which could take place prior to meeting with a service user, who may then present a range of interpersonal challenges. It is likely then, that being exposed to this "toxic" forensic environment day-to-day places significant occupational stress on clinicians. Furthermore, the theme of a lack of exposure to what was considered 'normality' during the course of the working day may further contribute to burnout:

*B: "being in this toxic environment all day [...] and that may or may not be seeing services users [directly], I think a bit of both, it can be toxic in different ways... being locked up*

*F: // coming into contact with a bit of normality is needed"*

It was suggested that this combination of toxic material and environment, a lack of exposure to 'normality', holding responsibility for managing high risk offenders, and the unrelenting workload that clinicians had to endure was likely to lead to their stress responses being placed on "high alert" throughout the course of the day, and this might seemingly increase the risk of stress and burnout:

*D: "You put yourself in a toxic environment [...] and a lot of things will stimulate your fear responses [...] if you allow that to remain at a high level for too long that's kind of [...] the quickest route to burnout... and even just reading about things that are horrific is going to trigger your brain [...] and go oh THIS is scary".*

It was also felt that at times it could feel as though one is 'treading water' with service users, which can make the nature of the work difficult, and has the potential to create a sense of lack of personal accomplishment:

*C: "There's also something around managing expectations for me cos I came into this kind of work wanting to help people make changes in their lives and there is a real frustration [...] it can be quite sad sometimes, if you can't find a way forward for that person at that point in time".*

Whilst it could be said that one would encounter the same challenges working in generic mental health services, in terms slow progress made by service users, this idea of 'slow progress' seemed relatively pervasive.

## **2. Team Cultures**

The team suggested that they were "not very good at taking breaks", and that this may be a contributing factor to stress and burnout:

*B: "... I was at [location] yesterday which is where some of our new colleagues are based, and at the end of the day I went to the corner shop to buy a drink before driving home, and thought, oh a shop, maybe people do this here, [laughs] and I thought [...] how nice and culturally, it was just a bit different".*

There appeared to be a culture of not using breaks to refresh oneself, instead opting to eat at their desks:

*C: "when we first started there's a canteen on the floor above and then it got to a point where it was like, its more interesting to sit at my desk and exchange comments with my colleagues than sat in this canteen area by myself eating lunch [laughs]".*

One contributing factor to not taking breaks might be feelings of guilt that clinicians experience for taking breaks, despite recognising that it was in their best interests to do so:

*D: "you feel guilty if you're not doing it [working], there's a tendency for each individual to do more than they should, cos they have that guilt punishing them for taking breaks".*

By not taking regular breaks and leaving the toxic environment, this may perpetuate that aforementioned lack of exposure to normality in a working day, and thus increase the risk of



burnout. Interestingly, it was suggested that the physical design of the building was not conducive to them stopping and taking breaks:

*A: "there's something about the design of this unit... so there's that table there which people sort of walk past and look busy and don't stop to talk if they are doing something and that's about it really so there's no place to stop and have lunch, so people work through lunch and work on computers or whatever else so institutionally it's not set up for that".*

In summary, it would seem that not taking regular breaks was seen to increase the risk of burnout. Interviewees talked about a culture within the team of "doing more than we should" (D).

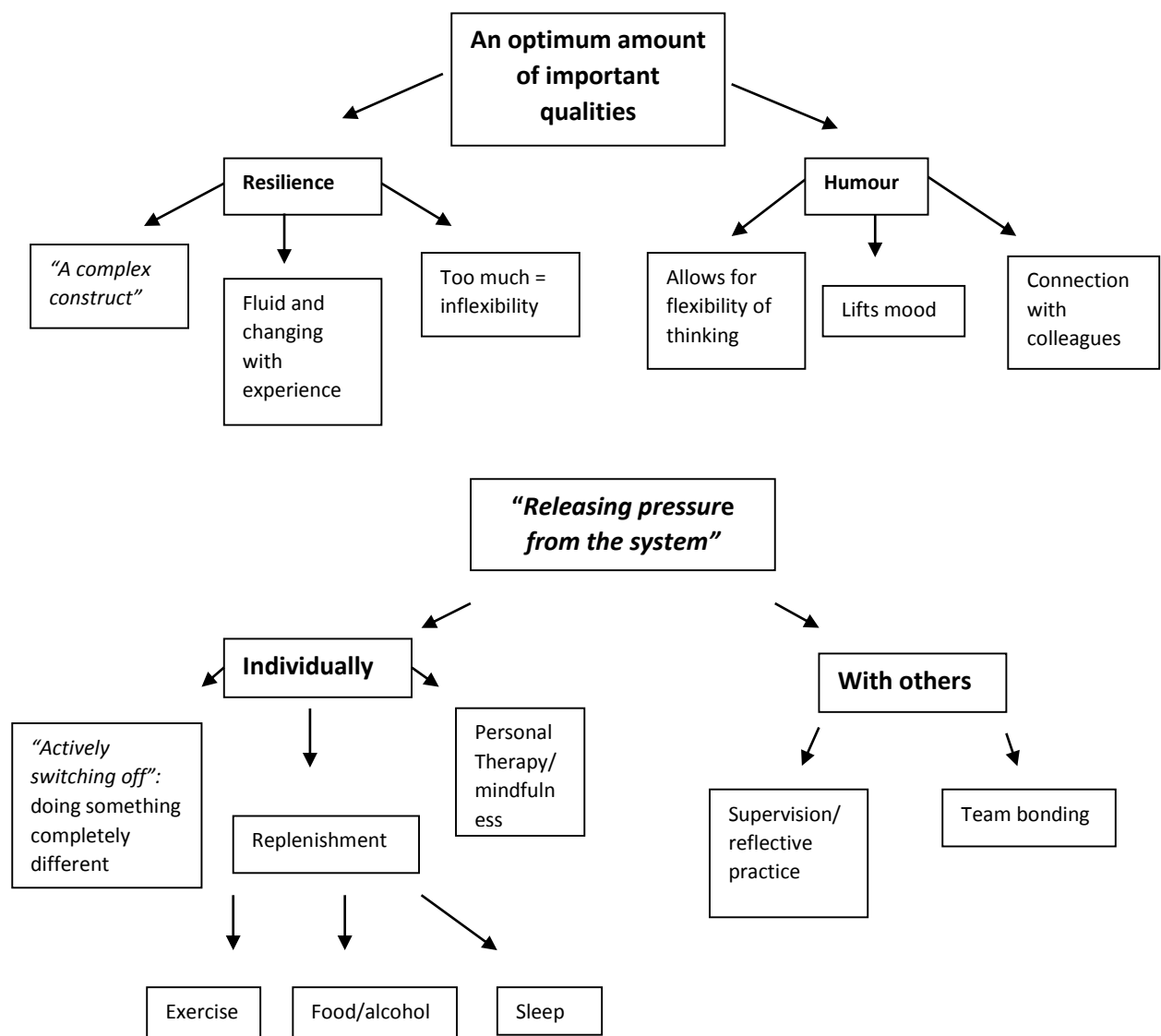
*E: "there has often been a culture of working very late".*

*B: "there's quite a big expectation on this team, it's a relatively new service compared to other services, that we will do well and get on with it, and I think some of that is perpetuated in our own work and our own expectations of ourselves".*

It would seem then that there may be the temptation for team members to go above and beyond, by working later and 'getting on' with the work that they have. This may be because of personal expectations, or the perceived expectations placed on clinicians by management and service commissioners.

## b. Minimisation the risk of burnout

Figure 2: Ways in which the risk of stress and burnout is minimised by clinicians working within the team



## 1. An optimum amount of important qualities

Two prominent qualities emerged that were seen as important in reducing working with offenders with PD: humour and resilience. However, it was not suggested that having more of these qualities was preferable; instead, it was suggested that there is an 'optimum amount' of these desirable qualities. It was suggested that defining resilience was a complex construct:

*A: "resilience is, suppose, toughness [agreeing mumurs]"*.

*B: "I think it's about having a sense of robustness... you need to have some kind of inner strength, some kind of tolerance... I think resilience is a complicated thing, I think there's different strands to it"*.

It was suggested that resilience was a fluid concept that developed with experience, and that it is not a static concept;

*C: "I think the professional one has developed with time and experience and wasn't there as much in my first year of doing this... I think I'm a lot more resilient over time"*.

Interestingly, participants felt that too much resilience (i.e. not being sensitive enough to the type of work or the material being dealt with during one's work), would mean that clinicians may become too inflexible or rigid in their thinking:

*B: "I wonder if it's a continuum actually [...] I wonder if too much resilience can make you tough minded or perhaps burnout and I wonder if it is similar to some other ideas thinking about because otherwise you could become a bit complacent, or yeah a bit too tough, and yeah not sensitive enough to the information, the feeling or the process because you're trying to be too resilient to try and get you through it"*.

It might be suggested that striving to be too robust (which would be understandable in this working environment) may be counterproductive and not allow for enough sensitivity when working therapeutically with service users. Another quality that was seen as important in optimum amounts was humour:

*D: "FOR ME my humour is about sort of logging with the absurdity of some of these things, no matter how things are ridiculous they are we can laugh about them, so for me that's what humour is about"*.

*B: "When I do it, it's not to humiliate it's to fulfil another function, sometimes things can get so dark and serious and heavy and stressful that to have a bit of a joke or to see the, you know how ridiculous, or trivial side of something can just lift things for a moment"*.

Much like resilience, humour was seen as an important factor in working with offenders with PD, in that it allowed for flexibility in thinking:

*A: "If I'm trying to get my head around something serious and nasty and difficult, and it feels like quite a personal thing to be able to offer different perspectives in whatever way, it humour can start to allow some flexibility, and well, I'm not just being nasty and serious all the time".*

Humour, more generally, was seen to lift one's mood, which could be a contributing factor to reducing burnout. It might also be hypothesised that humour might be used as a temporary distraction from unpleasant experiences:

*E: "I think humour is a really effective way of changing a mood, and if someone is having an argument with someone and you can make them laugh you can, I think it's just really useful".*

It was felt that humour enabled colleagues to 'connect' with one another on a personal level, which was seen as protective against burnout. There are two important things here; firstly, that humour again seems to serve as a distraction from the emotive nature of the work, and also that colleagues are able to introduce a new way of thinking about a situation or experience, which may be protective:

*E: "One function is that it allows you to connect with people in the team, when you're dealing with dark material [laughs] to find another way of looking at something so, an alternative perspective, but I guess it's also to quite, it's a defence isn't it, to allow some detachment from the [laughs] the really horrific, emotive things that we have to deal with".*

### **Releasing pressure from the system**

A second distinctive theme that arose was the idea of 'releasing pressure from the system'; the idea that when stress rises (which it inevitably will due to the "toxic" environment), participants need to release some of this pressure. This was seen to be achieved in one of two ways; firstly, by using others (see below), and also on an individual basis by actively "switching off" and taking part in an activity or hobby outside of work that was seen as completely different:

*D: "it has to be quite active, you have to actively discharge, the things you've absorbed in the week, so sitting around relaxing doesn't quite cut it because it stays there with you, you have to find an activity that kind of taps into what you're feeling and purges that for you".*

One common theme seemed to be the idea of replenishment, or "putting something back into the system" (A).

This was achieved in one of three ways; sleeping, eating or drinking and exercise:

*A: "Sleep helps*

*Researcher: // sleep's a good one*

*B: // alcohol, but not too much of it!"*

*B: "interestingly in the prison there is a gym and there is a culture of some of the staff use it after work some in lunchtime".*

Participants suggested that personal therapy, or mindfulness meditations may be beneficial for reducing the impact of stress and burnout:

*F: "Another that has been useful I've had personal therapy and actually I've found that to be quite helpful just as a sort of [...] containing perhaps, and perhaps if there are some things on my mind, just having that additional support is useful".*

Participants suggested that making use of supervision and/or reflective practice was beneficial to reducing stress and burnout:

*C: "It's important to know where you're at, what you should be taking to supervision, getting support with, with people who might [...] might not but might push buttons".*

Team away days and team lunches, which presumably would foster the cohesiveness within the team, were seen as useful in minimising stress and burnout:

*B: "having like a team lunch, just going into [building], taking lunch and sit on the grass if it's nice weather, and just sort of taking the time to down tools".*

Finally, interviewees discussed the organisational pressures upon them, and it seemed important to participants that senior level management should also recognise that good practice occurs:

*B: "some support from the senior managers to say you're doing this well".*

*A: "reflecting on the organisational pressures and expectations is quite important, there's quite a big expectation on this team"*

## **Discussion**

The results indicate that levels of burnout in a forensic PD service appear to be higher than in previous research in generic PD services with mean scores across all three subscales of the MBI demonstrating elevated levels of burnout compared with Crawford et al., (2010). There was significantly higher burnout reported in the current study, compared to Crawford et al. (2010), in terms of personal accomplishment. The current sample's mean score for Emotional Exhaustion exceeded the threshold for 'high' burnout, when compared with normative data for the MBI. Qualitative findings identify how burnout may be maintained within a forensic PD service; the environment and work can be *"toxic"*, and contributing factors including complex and risky cases, being faced with moral and philosophical questions, at times a lack of positive outcomes with service users, and not taking regular breaks may contribute to elevated levels of burnout. Strategies for reducing the risk of burnout, which included ensuring that breaks are taken, and developing one's own strategies for *"releasing pressure"* when stress responses were heightened, were also identified.

One factor that may account for increased levels of burnout could be the added complexity and challenges of working with *offenders* with PD; Crawford et al.'s (2010) research was undertaken with clinicians from generic PD services, where it is possible that risk, complexity and the perverse nature of material encountered by clinicians is likely to not be as pronounced in Crawford's sample, in comparison to the current forensic sample. This idea of added complexity and challenge seems to be supported by the qualitative findings of the project, which described the existential and philosophical questions that are encountered in the work, the perverse nature of material, and at times complete lack of progress with offenders with PD. However, some of the themes found may not be specific to forensic PD services, as a lack of personal accomplishment and feelings of being 'stuck' when working with service users with PD are commonplace in generic PD services (Perseus et al., 2007). Whilst it must be acknowledged that these themes are likely to be encountered by

clinicians in generic mental health services, it might be that the number, intensity and consistency with which these factors are encountered is what potentially sets forensic PD services apart from generic services. To ascertain whether there is an added 'forensic' aspect to working with service users with PD, future research might look to compare cross-sectional levels of burnout between different groups, for example, by comparing a team of community forensic PD clinicians with a team of community PD clinicians.

Nearly half of the participants in the current study reported 'high' levels of Emotional Exhaustion on the MBI. It is worth noting that at the time the current project was undertaken, there was a significant service redesign taking place; it may be that the elevated levels of emotional exhaustion found in this study reflect an unsettled period within the service. There is literature to suggest that NHS service redesigns place excessive demands and can be a source of stress for clinicians (Langan-Fox & Cooper, 2011; Locock, 2003), and clinicians may be at risk of disengagement, emotional exhaustion and a lowered sense of personal effectiveness (Loretto et al., 2005). This explanation might account for increased levels of emotional exhaustion, as clinicians may have been feeling despondent as a result of the service redesign. Indeed, this idea was supported by data from the focus group (E: *"there is this redesign going on and people are feeling devalued and downright furious"*). It is possible then, that perhaps one of the causal factors in the increased levels of burnout in the current study was in fact the service redesign that was taking place, as opposed to the day-to-day work of clinicians working with offenders with PD. Indeed, the actual number of hours worked directly with offenders per week (3.22) was found to be relatively low, and given that increased patient contact has been shown to increase burnout (Langan-Fox & Cooper, 2011), it is plausible that other factors, other than the nature of forensic PD work, are relevant in the increased levels of burnout within the current sample.

Reduced feelings of personal accomplishment were reported by the current sample compared with the Crawford et al. study. One possible explanation for this might be the lack of direct time spent with service users. On average, clinicians in the current study spent around two and a half hours per week with service users. Unfortunately, data from direct contact time with service users from the Crawford et al. (2010) study was not collected, so direct comparisons of this cannot be made. Whilst this idea would be contrary to previous findings that both reduced direct contact with patients, and reduced emotionally charged encounters with patients is correlated with lower levels of stress and burnout (Cronin-Stubbs & Brophy, 1985; Langan-Fox & Cooper, 2011; McVicar, 2003), it must be held in mind that these findings often come from the nursing and medical literature. Therefore, the idea that a lower level of direct patient contact may predict a lower sense of personal accomplishment in clinicians working with offenders with PD is a hypothesis that requires further attention in future research. However, one might argue that spending increased direct time with service users might in reduce a sense of personal accomplishment, given the idea that this is a service user group where progress may be slow.

More generally, the higher levels of burnout demonstrated in the current service may be reflective of the idea that clinicians are more *aware* of the impact that their work can have, as opposed to being more burned out; the service utilises frequent reflective practice (mean = 0.94 (SD = 0.17)) and supervision (1.47 (1.08)), suggesting that there is opportunity for reflecting on the emotional impact of working with offenders with PD. Potentially, what appears to be elevated burnout as measured by the MBI, may in fact be a reflection of the insight clinicians have with regards to their own emotional experiences regarding their work.

The main themes that emerged in terms of factors that increase the likelihood of burnout related to the toxic environment and team cultures, specifically going 'above and beyond' and not taking time

for breaks which would seem to allow from a release from the toxic environment. Psychological detachment, or 'switching off', from work is important in retaining mental well-being; a wealth of literature in the field of occupational psychology suggests people that detach from work are generally more satisfied at work and experience fewer symptoms of psychological strain (Sonnentag, 2012; Sonnentag, Kuttler, & Fritz, 2010). This idea of "*actively switching off*" was found to be helpful by interviewees. Research has demonstrated that increased workload is negatively correlated with psychological detachment (Sonnentag & Bayer, 2005), suggesting that the higher volume of one's work, the more difficult it may be to detach from thoughts and emotions that are evoked by such work, which is likely to increase the risk of burnout. It may be useful for service managers to ensure that workload capacity is managed well within services.

### **Limitations**

The quantitative results of this project were based on a sample of nine clinicians, and so the generalisability of results to the wider team is somewhat limited. Further to this the quantitative results of the current project are underpowered, and so making firm statistical inferences based on underpowered results would be unwise. Having said this, the demographic information that was collected would suggest that variables such as length of service and number of contracted hours was varied, and diversity seemed to be well represented within the sample. Additionally, the majority of clinicians that participated in the focus group were psychologists, which again limits the generalisability of findings to the wider team. It might be that some clinicians did not opt to take part in the focus group, as they may have felt uncomfortable with discussing their personal views on a sensitive topic in front of others. To address this issue, future research could employ purposeful sampling, or perhaps offer individual or telephone interviews.

Although levels of burnout seem to be elevated, there are methodological limitations associated with the MBI as an instrument to measure burnout: Morse, Salyers, Rollins, Monroe-DeVita, and Pfahler (2012) note that the cut-off scores for "high" burnout (as indicated by the MBI) in mental health workers are relatively low compared to other occupational groups, and that empirical validation of the cut-points on the MBI is somewhat lacking. Therefore, findings should be taken with caution, as the relatively low cut-off scores for "high" burnout in mental health workers may inflate the prevalence of burnout. However, there did seem to be a consensus from focus group participants that levels of burnout within the team might be high, and this was supported from the themes that emerged in the focus group.

### **Practical Implications**

There is a body of evidence showing that burnout reduction programmes can be an effective way to reduce burnout in mental health staff, which may include cognitive behavioural therapy for stress reduction, assertiveness training, or communication training for supervisors (Morse et al. (2012); Salyers et al. (2011); Paris and Hoge (2010). However, very few interventions have been evaluated, and those that have often have methodological weaknesses in terms of their design (e.g., a lack of randomised controlled trials). Many are expensive at a time of reduced financial resources within the NHS. In addition, much of the evidence is taken from burnout management programmes outside of the mental health field (see Morse et al. (2012) for a full review).

The findings from this project would suggest that fostering team cohesiveness via means such as shared lunches, regular team meetings and utilising humour in day-to-day conversations may be simple useful interventions. Further to this, the qualitative findings, both in terms of “*doing something completely different [to working]*” and “*replenishment*”, would suggest that retaining a work life balance is important, and treating oneself with compassion outside of the work environment may be protective in this area of clinical practice.

The findings would also indicate that reflective practice, supervision and sound clinical and managerial leadership are viewed as protective factors against burnout. This suggests that even at times when clinicians may be under great pressure within services, these sources of support should not be underestimated in terms of their protective function against burnout.

### **Implications for practice**

- Clinicians working in community services with offenders with personality disorder may be at an increased risk of burnout, when compared with clinicians from generic Personality Disorder services.
- Team cultures of being determined and hard working, or ‘going the extra mile’, may place a clinician at increased risk of burnout.
- Strategies for minimising burnout may be implemented at an individual level, and team level, and/or a service level. At the individual level, this may include; supervision, individual therapy and developing a hobbies and interests outside of work that allow for psychological detachment.
- At the team level, it may be necessary to ‘shift’ team cultures which may not easily allow for breaks to be taken. It will be important for teams to foster a sense of cohesiveness, through shared activities which have a non-clinical focus.
- At a service level, managers and commissioners should be mindful that there may be a link between increased workload and a reduced ability to detach from one’s work. Services should also be mindful of the protective effects of supervision and reflective practice for clinicians working with offenders with Personality Disorder.

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